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Chapter 305 of the Acts of 2008: *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*

The commission (i) shall examine payment methodologies and purchasing strategies, including, but not limited to, alternatives to fee-for-service models such as blended capitation rates, episodes-of-care payments, medical home models, and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies, (ii) recommend a common transparent payment methodology that promotes coordination of care and chronic disease management; rewards primary care physicians for improving health outcomes; reduces waste and duplication in clinical care; decreases unnecessary hospitalizations and use of ancillary services; and provides appropriate reimbursement for investment in health information technology that reduces medical errors and enables coordination of care, and (iii) recommend a plan for the implementation of the common payment methodology across all public and private payers in the commonwealth, including a plan under which the commonwealth shall seek a waiver from federal Medicare rules to facilitate the implementation of the common payment system.

TESTIMONY
Friday, February 6, 2009

Good morning. Thank you, Mr. or Ms Chairman and members of the Committee, for the opportunity to testify before you. My name is **Ann Stewart and Richard Flaherty**, and I represent patients in the State of Massachusetts as a State Policy Liaison with the National Patient Advocate Foundation.

National Patient Advocate Foundation is a policy organization based in Washington, D.C. that is dedicated to providing the patient's voice in order to improve access to health care at the federal and state levels. NPAF's companion organization, Patient Advocate Foundation is a direct patient services organization which provides case management services to patients throughout the country seeking information and assistance for access to care issues resulting from a diagnosis of a chronic, debilitating or life-threatening disease. In 2007, PAF received 66,194 contacts from Massachusetts residents; of those, 430 became full patient cases.

On behalf of the National Patient Advocate Foundation, I would like to talk with you today about three payment methodologies and purchasing strategies our organization believes are instrumental in providing incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.

Health Information Technology

National Patient Advocate Foundation supports the rapid deployment of health information technology (IT) and wishes to ensure that patient concerns including privacy and security safeguards are considered in the development of health IT policy, standards and innovations. Health IT remains a critical issue relative to both health care access and quality. NPAF supports widespread adoption and use of health IT to help reduce the nearly 100,000 deaths that occur each year due to medical errors. In addition, health IT would improve the quality of care, reduce duplicity, and increase medical efficiency for patients.

Financial assistance for smaller primary care practices to adopt health information technology would also provide a strong incentive to collaborate with community health teams.

Value Based Purchasing

National Patient Advocate Foundation supports provider reimbursement methodologies that integrate provider performance and payment incentives into reimbursement and fee-schedule determinations, otherwise known as value-based purchasing or pay for performance. This payment model seeks to reward physicians, hospitals and other providers for meeting certain measures of quality and efficiency for medical care they provide.
National Patient Advocate Foundation favors value-based purchasing methodologies designed to offer incentives for the delivery of high-quality care, rather than penalizing those services that do not meet the prescribed standards. We believe that incentives that encourage improved quality of care delivered would be a benefit to both patients and providers. We therefore recommend that these reimbursement systems be compensatory in nature, not punitive.

NPAF recognizes that adequate reimbursement for professional services is an essential component to ensuring patient access to care. NPAF also recognizes the need for maintaining strict safeguards to protect the safety and well-being of health care consumers. Implementing performance-based programs may contribute to appropriate reimbursement standards and may likely advance the safety and quality of care and its delivery.

Medical Home

Strengthening the role of primary care requires a multi-pronged approach. NPAF supports initiatives to improve our primary care system by ensuring accurate prices for primary care services, providing an add-on bonus payment for primary care services, and encouraging implementation of the medical home model. NPAF also calls out the importance of ensuring the viability of community health centers and rural health clinics that provide vital safety net functions and serve as a true medical home for thousands of patients across the state.

Expanding the medical home model — in which practitioners are paid explicitly for comprehensive care management services — represents a primary care plan initiative that

would promote quality, efficiency and care coordination. A growing body of evidence suggests that medical homes may improve patient health and reduce costs. We encourage the commission to examine the preliminary success The State of North Carolina has with the community health team model in its state Medicaid program.

Medical home programs should focus only on providers who are committed to ensuring that patients truly receive the primary care and care management services that the medical home is designed to deliver. Providers seeking to participate in a medical home expansion program should meet a set of stringent service and capacity criteria in order to qualify, and be willing to have additional payments based in part on the quality of care they deliver. In addition, careful consideration should be paid to the role of non-physician providers, such as nurse practitioners, home health aides, nutritionist and social and mental health workers in the medical home model. Medical home expansions should also target the patient populations most in need of comprehensive care management and coordination, particularly those with multiple chronic conditions.

Health IT, value-based purchasing and medical home concepts are works in progress, and the involvement of patient groups is critical to ensuring that these models remain patient centered.

On behalf of National Patient Advocate Foundation, I thank you for the opportunity to provide testimony today.